Kerrville Pediatrics Patient Registration

Child 1: Last Name: _____ First Name: _____ MI:_____

DOB: ____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Not Hispanic / Unknown Race: Am. Indian or Alaskan / Asian / Black / Hawaiian /White / Unknown

Child 2: Last Name: _____ First Name: _____ MI:_____

DOB: ____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Not Hispanic / Unknown Race: Am. Indian or Alaskan / Asian / Black / Hawaiian /White / Unknown

Child 3: Last Name: _____ First Name: _____ MI:_____

DOB: ____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Not Hispanic / Unknown Race: Am. Indian or Alaskan / Asian / Black / Hawaiian /White / Unknown

Mailing Address:

_____

(Street or PO Box) (City) (State & Zip)

Home Phone: (_____) _____ - _____

Who lives at this household? _____

Preferred Pharmacy: _____

Primary Care Provider: _____

Parent Name: _____

Biological Relation to Patient: _____ Lives with Patient? Yes / No

Date of birth ____/____ / _____ Email Address: _____

Work phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

How would you prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Work Phone / Cell Phone / Email

Recall Notices: Home Phone / Work Phone / Cell Phone / Email

Billing Statements: Home Phone / Work Phone / Cell Phone / Email

Patient Portal Notifications: Home Phone / Work Phone / Cell Phone / Email

Parent Name 2: _____

Biological Relation to Patient: _____ Lives with Patient? Yes / No

Date of birth ____/____ / _____ Email Address: _____

Work phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No / _____

Insurance:

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____ ID# _____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____ ID# _____

If parents are divorced or separated, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please provide a copy of any legal paperwork that supports this restriction.

Emergency Contacts, other than parents:

1. _____ Relationship: _____ Phone: (____) _____ - _____

2. _____ Relationship: _____ Phone: (____) _____ - _____

3. _____ Relationship: _____ Phone: (____) _____ - _____

Kerrville Pediatrics

J. Christopher Meriwether, M.D.
Michael S. Fontenot, M.D.
Carena Sears, CPNP

1331 Bandera Hwy, Suite 10
Kerrville, TX 78028
(830) 257-1440

General Consent for Treatment

The undersigned parent of guardian of _____, knowing that the child is suffering from a condition requiring diagnostic, medical, or surgical treatment, do hereby voluntarily consent to such procedures and care into such medical, surgical, or other services under the general and specific instructions of either J. Christopher Meriwether, M.D., or Michael S. Fontenot, M.D., P.A., or Carena Sears, CPNP, or their assistants, or their designate as is necessary in their judgement.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me, as a result of treatments or examination by either J. Christopher Meriwether, M.D., or Michael S. Fontenot, M.D., or Carena Sears, CPNP.

Insurance Assignment and Release

I, the undersigned, do hereby authorize J. Christopher Meriwether, M.D., and/or Michael S. Fontenot, M.D., and/or Carena Sears, CPNP to release to my insurance company any and all medical information, of whatever nature, now in their possession or later acquired, from whatever source, which pertains to or relates to my child's medical care. This authorization in consent is granted for the sole and limited purpose of facilitating the quality of medical care conducted by J. Christopher Meriwether, M.D., and/or Michael S. Fontenot, M.D., and/or Carena Sears, CPNP. I am releasing those rights and claims of confidentiality and privilege concerning the information I described which may otherwise exist, when used for the purposes I described. I further understand and agree that I may withdraw my authorization and consent at any time by written notice of withdrawal to the office of Kerrville Pediatrics, provided however, that any such withdrawal will not affect any information disclosed prior to receipt by the office of the written notice of withdrawal.

Payment Policy

All professional services rendered of charged to the patient, the patient is responsible for payment regardless of insurance coverage. Full payment is expected at the time of each service unless arrangements have been made in advance. Billing information will be provided to expedite patient reimbursement from private insurers.

Authorization of Payment

I authorize release of any medical information necessary to process a claim. I also request payment of benefits to either myself or to the party who accepts assignment.

Acknowledgement and Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature Dat